

California State University, San Bernardino

**CSUSB ScholarWorks**

---

Theses Digitization Project

John M. Pfau Library

---

2004

## Continuing education for nurse's aides

Mary Kay Ruf

Follow this and additional works at: <https://scholarworks.lib.csusb.edu/etd-project>



Part of the [Vocational Education Commons](#)

---

### Recommended Citation

Ruf, Mary Kay, "Continuing education for nurse's aides" (2004). *Theses Digitization Project*. 2634.  
<https://scholarworks.lib.csusb.edu/etd-project/2634>

This Project is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact [scholarworks@csusb.edu](mailto:scholarworks@csusb.edu).

CONTINUING EDUCATION FOR NURSE'S AIDES

---

A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

---

In Partial Fulfillment  
of the Requirements for the Degree  
Master of Arts  
in  
Education:  
Career and Technical Education

---

by  
Mary Kay Ruf  
June 2004

CONTINUING EDUCATION FOR NURSE'S AIDES

---

A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

---

by

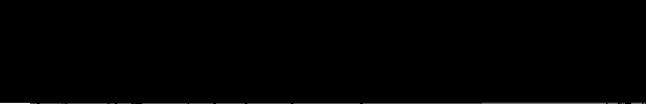
Mary Kay Ruf

June 2004

Approved by:

  
Joseph Scarcella, Ph.D. First Reader

5/4/04  
Date

  
Ronald K. Pendleton, Ph.D., Second Reader

© 2004 Mary Kay Ruf

## ABSTRACT

The purpose of the project was to develop an instructional manual on In-service Education for Certified Nurses Aides. The context of the problem was to address the lack of a standardized instruction manual for continuing education for certified nursing assistances.

In 1970 it was determined that nurse's aides should have a formal education, with a set curriculum, and a minimum number of classroom hours, to obtain a certificate. In addition to the Certification class it was mandated by the State of California that nurse aids have 48 hours of continuing education every two years. The state mandates twelve subjects to be covered, ranging in length from one hour to four hours. The purposes of continuing education, is to keep all staff current on health care issues, reinforce previous teaching, and monitor techniques. The population that will be served is the staff developer, and the certified nurse's assistant. The project, an instruction manual, was developed as examples of classes for staff developers to use when teaching continuing education classes.

## ACKNOWLEDGMENTS

There are many people to whom I am grateful for their help, encouragement, advice, and support along my journey.

The excellent facility and friends that I have encountered at California State University, San Bernardino, who have made a significant impact on my education: Dr. Ronald K. Pendelton, Dr. Joseph Scarcella, Mr. Timothy Thelander, Dr. Deborah Stein, Dr. Thomas Gehring.

I would like to thank my friends, who usually understood why I had to stay home and do my homework, I am glad you are still there.

## TABLE OF CONTENTS

ABSTRACT .....	iii
ACKNOWLEDGMENTS .....	iv
LIST OF FIGURES .....	vii
CHAPTER ONE: BACKGROUND	
Introduction .....	1
Purpose of the Project .....	1
Context of the Problem .....	1
Significance of the Project .....	2
Assumptions .....	3
Limitations and Delimitations .....	3
Limitations .....	4
Delimitations .....	4
Definition of Terms .....	5
Organization of the Thesis .....	5
CHAPTER TWO: REVIEW OF THE LITERATURE	
Introduction .....	7
A Brief History .....	7
The Beginning .....	9
Responsibilities .....	10
Training .....	10
Continuing Education .....	12
Summary .....	13

### CHAPTER THREE: METHODOLOGY

Introduction .....	14
Population Served .....	14
Development .....	14
Resources and Content Validation .....	15
Design .....	18
Summary .....	19

### CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS

Introduction .....	20
Conclusions .....	20
Recommendations .....	21
Summary .....	21

APPENDIX: CONTINUING EDUCATION FOR CERTIFIED NURSES ASSISTANCES .....	22
--	----

REFERENCES .....	68
------------------	----



## LIST OF FIGURES

Figure 1. Subjects Studied .....	11
----------------------------------	----

## CHAPTER ONE

### BACKGROUND

#### Introduction

The contents of Chapter One present an overview of the project, which addresses the need for a standardized instruction manual for continuing education for certified nursing assistants.

#### Purpose of the Project

The purpose of the project was to develop an instructional manual on Continuing Education for Certified Nurses Aides. This manual may aide Staff Developers in presenting a consistent philosophy of care and safety. As nurses typically change facilities every three years, it would behoove the facilities to maintain consistency throughout the field.

It will also save the Staff Developers the time to design and develop the individual modules.

#### Context of the Problem

The context of the problem was to address the lack of a standardized instruction manual for continuing education for certified nursing assistances. Although the

State of California mandates that 12 specific in-services be given on an annual basis there is no publication available to address the in-services. At each and every hospital there is a Staff Developer, this person is responsible for the design, development, delivery, and the continued re-evaluation of the 12 mandated modules. "Hospitals have been somewhat slower than industry in accepting responsibility for in-service training of employees. In fact, in many nursing homes today, such programs may be limited to on-the-job training for nursing assistants. A well-planned, effective in-service program can contribute substantially to the practicing nurse's education" (Popiel, 1973, p. 8). "Conversely, poorly planned programs may have a very negative effect on patient care, staff attitudes, attendance, and overall job satisfaction" (Abruzzese, 1992, p. 5).

#### Significance of the Project

The significance of the project was there are no current publication available for use in the teaching of these twelve mandated in-services (R. Darton RN Staff Developer & Z. La Sier RN Staff Developer personal communication, August 8, 2001). "In-service Education

should be established for all levels of nursing care" (Abruzzese, 1992, p. 8). It is the belief of this author that consistency is vital to both, ease of learning and the delivery of good health care. The assurance of a safe environment to deliver that health care is also of prime concern.

### Assumptions

The following assumptions were made regarding this project:

1. It was assumed that a standardized book of curriculum is needed for use by Staff Developers, to promote consistency throughout the field.
2. It was assumed that once the curriculum is established, it will be utilized throughout the state, by staff developers, which will promote consistency in the field.

### Limitations and Delimitations

During the development of the project, a number of limitations and delimitations were noted. These limitations and delimitations are presented in the next section.

### Limitations

The following limitations apply to the project:

1. The project is limited due to the lack of sufficient resource material.
2. There is currently no publication available with standardized curriculum for the 12 state of California mandated continuing education in-services.
3. This project will be dealing with only five (5) of the twelve (12) mandated continuing education in-services.

### Delimitations

The following delimitations apply to the project:

1. The modules for the mandated continuing education in-services may be utilized as resource material by Staff Developers.
2. The modules for the mandated continuing education in-services may be utilized as part of the twelve (12) continuing education classes required by the State of California.
3. The examples in the appendix may be used to build a complete twelve (12) unit continuing education in-service manual.

## Definition of Terms

The following terms are defined as they apply to the project:

*In-service Education* - "Learning experiences provided in the work place setting for the purpose of assisting staff in performing their assigned functions in that particular agency" according to (Abruzzese, 1992).

*Continuing Education* - Continuing education in nursing consists of planned learning experiences beyond a basic nursing education. These experiences are designed to promote the development of knowledge, skills, and attitudes for the enhancement of nursing practice, thus improving health care to the public (Tobin, Hull, & Wise, 1979).

*Mandated* - An authoritative order or command. Required by Law, State of California, Department of Health (California Code of Regulations, Title 22. Social Security).

## Organization of the Thesis

The thesis portion of the project was divided into four chapters. Chapter One provides an introduction to the context of the problem, purpose of the project,

significance of the project, limitations and delimitations and definitions of terms. Chapter Two consists of a review of relevant literature. Chapter Three documents the steps used in developing the project. Chapter Four presents conclusions and recommendations drawn from the development of the project. The Appendix for the project consists of: Cover Page, Title Page, Table of Contents, Section 1 Caring For The Elderly, Section 2 Alzheimer's Disease, Section 3 Infection Control, Section 4 Cardiopulmonary Resuscitation, Section 5 End of Life Care. Finally, the Project references.

## CHAPTER TWO

### REVIEW OF THE LITERATURE

#### Introduction

Chapter Two consists of a discussion of the relevant literature. A brief history of nursing and the origin of the position of the nurse's aide. The responsibilities and training of a nurse's aide. The continuing education requirements of the state of California for certified nurse's aides.

#### A Brief History

People have been taking care of people since the beginning of time. "Of all purely medical records so far discovered and deciphered, the oldest are Egyptian. Six sacred books dealing wholly with medical subjects cover the period, it is believed from 4688 B.C. to 1552" (Dock, 1920, p. 11). Many diseases and operations known today are carefully described and classified in the six sacred books. The books go on to describe hundreds of drugs and their classifications. Egyptian pharmacists made decoctions, infusions, solutions for injections, pills, tablets, troches, capsules, powders, inhalations, lotions, ointments, plasters, and other forms of



medicines used today. Egyptians have books on embalming, dentistry, and astrology. There was much written about physicians and the priest physicians but there is nothing to be found in these records about nurses and their tasks. According to Dock (1920), from ancient time to the present very little has been written about places where the sick were cared for. "There is nothing written about hospitals as such. This is strange as medicine, pharmacy, and sanitation were so scientifically developed" (Dock, 1920, p. 29). The Egyptians did write about people being cared for in the temples and the women who were "temple women" but no further reference exist as to what their roles might have been. From ancient time until today there has been very little written about nursing and even less about nurse's aides. It seems that documentation of nursing as a field started in the early 1900's, very little was documented prior to that time.

During World War I, the military employed one-third of all graduate nurses. This was not a problem until the flu epidemic of 1918 when civilian hospitals became markedly understaffed (Popiel, 1977).

In response to this flu epidemic, and the lack of nurses, the Red Cross began training nurse's aides to

ease the shortage, a concept hotly debated (Popiel, 1977).

The Surgeon General asked the Red Cross to enroll 1500 aides for use overseas. The armistice in November of 1918, however prevented the implementation of the nurse assistant plan (Popiel, 1977).

### The Beginning

Nurses have historically been busy, and frequently to busy for the number of people in their care. This was the reasoning behind the development of the position of the nurse's aide. These people, the nurse's aides, were caregivers who did not have the years of formal education that a licensed nurse had. Typically, there would be one professional nurse in charge of several assistants. These assistants would be given very specific functions to perform, and they were closely monitored by the nurse in charge. As late as the 1960's, anyone could claim to be a nurse's assistant, no formal training was required. To improve the quality of life and care the U.S. Congress passed the Omnibus Budget Reconciliation Act of 1987 (Sorrentino, 2000). This law sets minimum training and competency evaluation requirements for nursing assistants

working in the field. Each state must have rules for nursing assistant training and evaluation. A state requirement must be met before a person can work as a nursing assistant.

### Responsibilities

The nurse's aides were responsible for such simple things as giving a bath or passing fresh drinking water. As with all jobs, the scope, practice, and responsibilities of the nurse's aides have changed over the years, as have their training. As few as 25 years ago, anyone could get a job as a nurse's aide, no training necessary. Now however, due to the Omnibus Budget Reconciliation Act of 1987 (OBRA), there is strict accountability. The responsibilities have changed from bathing and passing water, to knowing patients rights, advanced directives, as well as how to operate the new and technological equipment used in hospitals today.

### Training

In 1970, it was determined that nurse's aides should have a formal education, a set curriculum. The State of California developed a curriculum, set the minimum number of hours in each subject and developed a state test for

one who has completed the classes and wishing to become a certified nurse's aide. The training for a nurse's aide includes but is not limited to the subject shown in Figure 1.

Subjects Studied	
1. Introduction to Health Care	11. Body Mechanics
2. The Nursing Assistant	12. Urinary Elimination
3. Work Ethics	13. Bowel Elimination
4. Communicating With the Health Team	14. Nutrition and Fluids
5. Understanding the Person	15. Vital Signs
6. Body Structure and Function	16. Wound Care
7. Growth and Development	17. Mental Health Problems
8. Care of the Older Person	18. Confusion and Dementia
9. Safety	19. Developmental Disabled
10. Preventing Infection	20. The Dying Person
	21. Medical Terminology
The Lippincott manual of nursing practice, 2001	

Figure 1. Subjects Studied

Figure 1 is a list of classes that are examples of the requirements for nursing aides. At the end of the classes, the nursing students take a state mandated test. If the student passes with an acceptable grade, they are given a certificate. The certificates are good for a two year period. During that two-year period, the Certified Nurses Aide must complete 48 hours of continuing education.

## Continuing Education

The state of California mandates twelve subjects to be covered, ranging in length from one hour to four hours. An example might be, oral hygiene 1-hour, dementia 4-hours. There are several ways to obtain the mandated classes. One can go to a local adult education program, or seek private education at a cost. In addition to the afore mentioned there is a third way. Most facilities have a staff developer that offers the classes at no cost to the nurse's aides. These classes are offered to the entire staff, and are given on site, and usually during working hours.

It is the contention of the state that the 12 subjects they chose are crucial to the health and well-being of all involved. This would include the facility, nurse, and patients. Although the 12 classes are mandated by the state, the state does not provide curriculum for teaching these classes. Each institution or individual staff developer must develop the curriculum within the guidelines of their facility.

The purposes of in-services are to keep all staff current on health care issues, reinforce previous teaching, and monitor techniques. The in-services will

also support good practices in the patient setting. Nurses themselves became concerned with self-evaluation in the 1960s with regard to patient care (Tobin, Hull, & Wise, 1979).

#### Summary

A brief history of nursing was presented, and what brought about the need for more help in the health care industry. How the position of the nursing assistant came into being. The passing of the Omnibus Budget Reconciliation Act of 1987 and the reasons for such an act being implemented. The roles and responsibilities of the certified nurse's assistant. The training program that is required. Also discussed was continuing education, the reasons this became a requirement and some examples of what is studied.

## CHAPTER THREE

### METHODOLOGY

#### Introduction

Chapter Three details the steps used in developing the project. Specifically, the population served was discussed. Next, the development process was presented. Resource and content validation was discussed in detail. Design process was also covered. The chapter concludes with a summary.

#### Population Served

The population that will be served by these classes are two fold, the staff developer that will be giving the class, and the certified nurse's assistant that will be taking the class for the mandated required hours of continuing education hours.

#### Development

The project was developed as examples of classes for staff developers to use when teaching continuing education classes. The purposes of the continuing education classes are to keep all staff current on health care issues, reinforce previous teaching, and monitor

techniques. The in-services education will also support good practices in the patient setting.

#### Resources and Content Validation

According to California Code of Regulations: Title 22. Social Security. Article 4. Continuing Education and In-Service Training the following is a directive. The content of the in-service training program shall enhance knowledge and skills learned in the certification-training program and shall also address areas of weakness as determined by a nurse's assistance performance reviews, areas of the patient, including those with cognitive needs, and areas wherein the facility received deficiencies related to patient care following the last licensing survey. Subjects may include, but are not limited to:

1. Working with patients who have special problems such as blindness, deafness, confusion or communication disabilities;
2. Bladder and bowel training and management;
3. Signs, symptoms and probable causes of patient distress with procedures to be followed for alleviating distress and emergency procedures for relief of choking;



4. Psychosocial aspects of aging and/or chronic illness as relevant to the individual, family and community;
5. Patient care elements including planning and organizing work while individualizing patient care; testing urine for sugar and acetone; measuring blood pressure and administering non-medicated enemas;
6. Nursing care relevant to body systems including, but not limited to, fractures, diabetes, cardiac disorders, dementia, cerebrovascular accidents, arthritis, pulmonary disorders, and infectious diseases including Acquired Immune Deficiency Syndrome (AIDS);
7. Nutritional needs of patients and related nursing interventions;
8. Oral hygiene;
9. Patient care conferences and patient care plans involving the patient and the family;
10. Improving skills in observation, reporting and recording of patient information;
11. Developing effective relationships and means of intervention on behalf of the patients;

12. Social and recreational need of the patient;
13. Working with the dying patient and the family;
14. Environmental safety including fire and accident prevention;
15. Universal precautions for infection control including methods to handle all patients and materials that are soiled with blood and /or body fluids from all patients. The methods prescribed shall be developed to reduce the risk of transmission of potentially infectious etiologic agents from patients and between patients and health care workers;
16. Patients rights and civil rights;
17. Disaster preparedness;
18. Sensory deprivation and stimulation;
19. Maintenance of Healthy skin: prevention of skin breakdown, body positioning and range of motion;
20. Use of adaptive equipment relevant to nutrition and physical dysfunction;
21. Safeguarding patients' personal property through compliance with the facility's theft and loss prevention program.

The advisory board of Knowledge Quest which is a group of nursing professionals, with an average of 27 years of experience. The committee consists of three RNs, with a minimum of five years experience, one President of a Private College with five years experience, two Curriculum Development Specialists each with a seven years experience; they have reviewed the project content and have determined that all state mandated requirements are being met. The examples meet and or exceed all requirements. The major recommendations put forth were to review the course content on an annual basis and update material as needed to include new information.

### Design

These curriculum examples were developed in alignment with the concepts and skills put forward by the Knowledge Quest Advisory Committee. During research, it was identified that numerous facilities offered similar in-service education classes, however each covered only information specific to their facility. Through careful review of existing outlines of these specific continuing education classes, the Knowledge Quest Advisory Committee identified the areas of basic skills required for a certified nursing assistant. The competencies identified

as essential to obtaining and maintaining meaningful employment, and good skills practice. Through a consensus of the Knowledge Quest Advisory Committee the following outline was developed: (1) lesson title; (2) lesson outline; (3) lesson objectives; (4) materials and equipment; (5) evaluation; and (6) comprehension.

### Summary

The philosophy for the development of the project was outlined, including the mandates from the State of California. The target population was described. The development process was covered. The resource and content validation was covered thoroughly, along with the design format.

## CHAPTER FOUR

### CONCLUSIONS AND RECOMMENDATIONS

#### Introduction

Included in Chapter Four was a presentation of the conclusions gleamed as a result of completing the project. Further, the recommendations extracted from the project are presented. Lastly, the Chapter concludes with a summary.

#### Conclusions

The conclusions extracted from the project follows.

1. During research for this project, the conclusion was made that since there was no curriculum readily available to staff developers for the purpose of continuing education this curriculum was necessary.
2. Programs of this type are needed to maintain consistency through out the medical field, that no matter where a certified nurses assistant acquires her continuing education units or hours the content will be the same, thus providing quality health care.

## Recommendations

The recommendations resulting from the project follows.

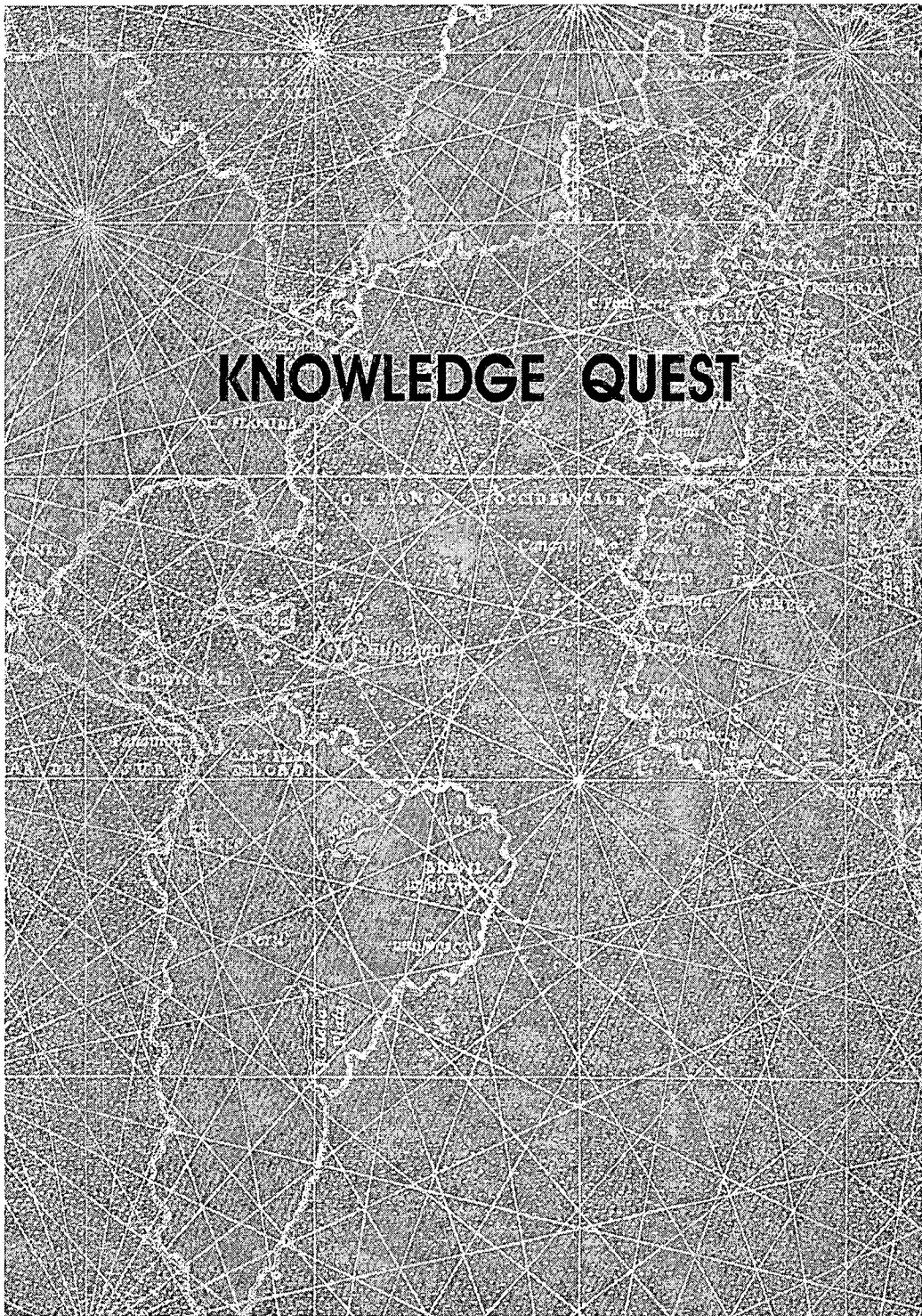
1. Continued development of continuing education classes is recommended to comply with California State Mandates.
2. It is recommended that more collaboration between Staff Developers be developed, to enhance the consistency of the classes developed.

## Summary

Chapter Four reviewed the conclusions extracted from the project. Lastly, the recommendations derived from the project were presented.

The recommendations for this project have been forwarded to the Knowledge Quest Advisory Board for review and implementation.

APPENDIX  
CONTINUING EDUCATION FOR CERTIFIED  
NURSES ASSISTANCES





***CONTINUING EDUCATION***  
***FOR***  
***CERTIFIED NURSES ASSISTANCES***

## **INTRODUCTION**

Changes in the health care system have created an increased need for educated and trained health care workers. The addition of the State mandated continuing education element was the driving force behind the development of this manual. This manual was developed to assist Staff Developers in the delivery and continuity of these subjects.

This information was compiled from many sources, and condensed into a simplified, but comprehensive and concise format to help staff developers assimilate the information to their students.

## TABLE OF CONTENTS

INTRODUCTION.....	25
SECTION 1: CARING FOR THE ELDERLY .....	30
Objectives:.....	30
Introduction .....	30
The Normal Changes of the Aging Process .....	30
Some Tasks for the Elderly .....	32
Thinking and Learning Abilities .....	33
Safety Needs.....	34
Food and Fluid Needs.....	34
How to Care for the Elderly Patient .....	36
SECTION 2: ALZHEIMER’S DISEASE .....	37
Objectives:.....	37
What is Alzheimer’s Disease?.....	37
What are the Signs of Alzheimer’s Disease? .....	37
Early Signs.....	38
People in the early stage also: .....	38
The Middle Stage Signs.....	38
The Late Stage Signs .....	39
How do People Find Out that They Have Alzheimer’s Disease? .....	39
Caring for Alzheimer’s Patients .....	40
Confusion. ....	40
SECTION 3: INFECTION CONTROL .....	44
Objectives:.....	44

What is Infection Control? ..	44
Why Are Infections A Big Problem in Hospitals and Nursing Homes? ..	45
People in hospitals and nursing homes are at great risk of getting an infection ..	46
Infections Cause Deaths, Longer Lengths of Stay and a Lot of Money ..	46
How Can Infections Be Stopped? ..	48
Standard Precautions ..	48
Handwashing Procedure ..	49
Gloves ..	49
Masks, Eye Protection & Face Shields ..	50
Gowns ..	50
Patient Care Equipment and Supplies ..	50
Environmental Control ..	51
Linen ..	51
Patients' Beds and Chairs ..	51
Transmission Precautions ..	51
Special Waste Handling ..	52
Safe Handling of Sharps ..	52
Keeping Yourself Healthy ..	52
Keeping Your Patients and Residents Healthy ..	53
Handwashing ..	53
Handwashing ..	54

SECTION 4: ADULT CARDIOPULMONARY RESUSCITATION.....	56
Deciding to Act.....	56
Emergency Action Steps .....	56
Checking an Unconscious Victim .....	57
Checking a Conscious Victim .....	57
If a Person is Choking .....	58
Rescue Breathing.....	58
Unconscious Choking Adult.....	59
Heart Attack.....	60
CPR.....	60
SECTION 5: END OF LIFE CARE.....	62
Objectives:.....	62
What Is End Of Life Care? .....	62
Meeting the Needs at the End of Life.....	63
Communication .....	63
Physical Comfort .....	64
Mental Comfort .....	64
Spiritual Comfort.....	65
Social Needs .....	65
Financial Needs .....	65
Post Mortem Care.....	65
Legal & Ethical Issues at the End of Life.....	66
The Right to Dignity.....	66
The Right to Make Decisions .....	66

The Right to Privacy & Confidentiality .....	66
A “Living Will”: Advance Directives .....	67
Medical Power of Attorney: Health Care Proxy .....	67
Summary.....	67

## **SECTION 1**

### **CARING FOR THE ELDERLY**

#### **Objectives:**

After you take this class, you will be able to:

1. Discuss the normal changes that occur during the aging process.
2. Describe the characteristics, needs and special tasks of the older adult.
3. Provide care to the older adult that is modified to meet their special needs and characteristics.

#### **Introduction**

Nursing assistants and other health care workers care for old patients and residents all over the world. In the United States today there are more old adults than any other age group. There are more old adults now than ever before.

The elderly are also living longer and longer. They are getting older and older. In the past there were not too many people who lived to 100-years-old. Now there are more 100-year-old people than ever before.

Nursing assistants, nurses and many others get a lot of joy as they care for older adults. They also have a lot of challenges and things that they must know about the old adult age group. The old adult age group has its own needs. We must provide care to the old adult that meets each patient's needs. These needs are best met when nursing assistants, nurses and many other health care providers know about the normal aging process. We must know how aging affects the care we give.

#### **The Normal Changes of the Aging Process**

As the human body ages, it slows down and it does not work as well as it did in the past. For example, digestion slows down. Foods that are eaten take longer to digest. It also takes longer to burn the calories that we eat.

Old adults do not have the same appetite that they had when they were younger. Their need for large amounts of food and calories is lowered. They may also not want to eat. If the sense of taste and smell are gone, they may not enjoy food as much as they did when they were younger.

Vision and hearing may also get poor as a person gets older. Many old patients and residents use eyeglasses, hearing aids and devices as they get older.

The old adult may also have weak muscles, unstable joints and poor balance. These things can make an old person fall or slip. Falls and slips can break bones and even lead to death.

Many elderly people also have long-term diseases that affect how we care for them. Many older people have diabetes, arthritis, Alzheimer's disease, heart, lung and kidney disease. They are also not able to fight off infections as well as they did when they were young. Old patients are at great risk of getting an infection, like pneumonia or a urinary tract infection, because their immune system has slowed down.

The aging process also affects their skin. The skin gets dry and easily irritated; it breaks down and tears very easily for many patients and residents. Also, the body temperature is not controlled as well as it was in the past. Old patients feel extremes of hot and cold more than younger people.

Mental ability also changes as one gets older. Mentally, many old residents and patients are confused. They forget things quickly. They are not able to remember recent events. They may not know the time of day, the day of the week or even the current year. Some do not know, or cannot remember, where they are and who they are. They are disoriented. They are not oriented to person, place and time. They may also be agitated and use poor judgment. Others may have delirium, dementia and depression.

All of these normal aging changes affect the kind of care we must provide to our aging patients.

The Age Groups	Age Group Age Span
Infant	Birth to 1 year
Toddler	1 to 3 years
Preschool child	3 to 5 years
School age child	5 to 12 years
Adolescent	12 to 18 years
Young Adult	18 to 45 years
Middle Age Adult	45 to 65 years
Old Adult	Over 65

Although an old adult is 65 years of age and older, it is not always clear when one age group ends and the next one begins. Some people in the old adult age group may be typical of the age group and others may not. Some people have the needs of their age



group. Others do not. I am sure that you have seen some 90-year-old patients or residents that look and act like they are 50. These people do not show the needs of the old adult age group.

So, please remember that not all old adults are same. All patients and residents should be cared for based on their own needs. However, knowing about the aging process helps us to guide care.

### **Some Tasks for the Elderly**

Erik Erikson, a psychologist, is the expert who listed the 8 major developmental tasks that every person must accomplish during their life.

Nursing assistants and other health care providers must know about these major tasks for each age group that they are taking care of. For example, nursing assistants who take care of adolescents must know that adolescents have to cope with identity formation- “Who am I?.” A hospital stay can affect an adolescent’s sense of self, it can also keep them from their friends or peer group, a group that is much more important to them than their own family. Their peer group helps them to define who they are.

Older adults, according to Erikson, have to share their wisdom, maintain their sense of self, have integrity and be happy with their life and what they have done. Old adults who can NOT do these tasks may be sad, depressed and unhappy. They may view their life as worthless and without meaning. They may think that they are useless. Some may feel that they are a burden to their family, friends and health care workers.

Old adults also have to deal with losses. They may lose their husband or wife, their friends and other people who they loved. They may feel lonely and not loved. They can also be very sad and depressed. As they get older and lose their own mental and physical health, they may NOT be able to care for themselves any more. This may make the patient or resident sad or angry.

All of these losses tell the old person that they, too, will die. Many old people plan for their own death. They write their will and their advance directives. They give their own things and prized possessions to their family and loved ones. Some older adults may think silently about these losses and their own death. They may also review their own life and what they have done in silence. Other old adults may speak about their losses to nurses, nursing assistants, social workers, family and others.

As a health care provider, we should listen to the older patient when they talk about their losses and their thoughts about death. These thoughts should also be reported to the nurse on the unit.

## Thinking and Learning Abilities

The thinking and learning abilities of the older adult affect how we communicate, instruct and teach them and their family members. Older adults need special care during communication and education. They often have a physical and mental problem that can interfere with learning and thinking.

Older adults may have:

- A short attention span. Old adults may not be able to understand long and detailed information. They may do better with short instructions.
- Less learning ability. Old people may not be able to learn new things as well as they did in the past.
- Less ability to understand. Many older adults are confused and not able to understand.
- An inability to communicate. Older adults may not be able to speak and ask questions. After a stroke, many patients have aphasia, a lack of ability to speak.
- Poor hearing and sight. Vision and hearing gets poor as humans age. Nursing assistants and others must give a patient their eyeglasses and/or their hearing aid so they can communicate with you and others.

When nursing assistants are communicating with an older patient, they should:

- Give the person their eyeglasses and hearing aid, if they have one
- Speak slowly and clearly while facing the person
- Keep information simple
- Use words that the person can understand
- Use pictures and large print material when you can
- Provide enough light if the patient will be reading
- Keep sessions short
- Repeat your communication as often as needed so that the patient can understand it and remember it
- Allow enough time for the patient. Some patients need more time than others.
- Make sure that the area or room is quiet
- Allow the person to talk and ask questions

- Include the husband, wife, and other loved ones in the communication and instruction process

### **Safety Needs**

The need for safety is one of our most basic of human needs. Safety is very important for all age groups but safety needs are the greatest for young children and the elderly. For example, infants put small objects in their mouths. These small things can be dangerous. They can eat pills, poisons and even choke on something small.

The old adult who has a mental, sensory (eyes, ears) or a physical loss, like poor balance and weak muscles, is a safety risk. These losses and the aging process make older adults prone to accidents. An old patient that has poor vision and hearing, is confused and has poor judgment can:

- Slip
- Fall
- leave the facility and get hit by a car
- drink a gallon of a cleaning chemical
- cut their hand off with an electric saw that was left on the unit
- chew all the pills in the medication cart

Physical problems, confusion, loss of hearing and vision, poor judgment and the inability to see danger when it exists are some of the reasons why healthcare providers must maintain a safe environment for the elderly. Safety is everyone's responsibility. Safety needs must ALWAYS be a priority even when you have a lot of work to do and you feel rushed. ALL patients and patient care areas must be safe and free of all dangers.

### **Food and Fluid Needs**

Food and nutritional needs also change as a person gets older and older. The need for a lot of calories decreases when a person gets older. These needs were highest when the person was an infant, a teenager and when they were pregnant or breast feeding their baby.

Old patients and residents need the least calories of all age groups. They do not burn calories and food as quickly as they did when they were younger and more active. This doesn't mean, however, that the elderly do not need a good diet. Older patients do need a good diet just like the other age groups.

The appetite and the digestive process also slow down as the human body ages. Old adults do not feel as hungry as they did when they were young. Also, when they eat

meals they feel full and they may not want to eat another meal for a long time. They may even skip a meal. Old adults often do better with small snacks during the day rather than large meals three times a day.

In terms of fluid needs (hydration), a patient or resident may not be able to swallow fluids. They may not even feel thirst when they should under normal conditions. We must, therefore, offer fluids very often to older people. Nursing assistants should ask their patients and residents if they want a drink of water every time they speak to them unless they are not allowed to drink.

Some other old people may not be able to safely drink liquids unless they are thick. They may choke with water, juice and other thin fluids like tea or coffee. Nursing assistants are often asked by nurses to give the patient water and fluids that are made as thick as honey. These thick fluids help provide fluids to patients who have trouble swallowing.

Aging people may also not be able to use a spoon or a fork. They may be too confused to know how to feed themselves. Their lack of ability to eat or drink often makes it necessary to go to an assisted living facility or a nursing home so that they can be helped with eating, a basic ADL. It is the nursing assistant that most often provides the necessary food and fluids to these patients and residents

Other things that can decrease the amount and kinds of food and fluids that an elderly person will eat are:

- Money. An old person will not get a good diet if they do not have the money to pay for it.
- Physical health. If a person is not able to drive or walk to the store, if they are not able to make and cook good meals, if they are not able to use a fork or a spoon, they will need the help of others to get a good diet and enough fluids.
- Mental ability. If a person is confused they may not be able to buy, cook and eat meals. Again, the help of others is need so that they get a good diet.
- Teeth. If a person has no teeth, poor dentures or is not given their dentures before a meal, they will probably not get a good diet.
- The ability to swallow. It is dangerous when a person chokes on food or fluids. It can cause death. Unless they get a tube feeding or special care, like thick fluids, these people will not get enough food and fluid.

Some of the other things that nursing assistants can do to help the patient or resident get a good diet and enough fluids include giving the aging adult:

- dentures, as needed
- a pleasant and nice dining environment
- nice looking, tasty and foods that the patient or resident chooses
- help with foods and fluids as needed
- plates, forks and other special items that help the patient or resident feed themselves
- smaller meals and fluids more often
- proper positioning for safe eating and drinking
- close monitoring, reporting and documentation of how much food or fluid is taken and sometimes how much urine is put out (intake and output)
- extra nutritional supplements, if ordered
- offers of food and fluid as often as needed when the diet and fluid intake is poor

### **How to Care for the Elderly Patient**

There are many parts of care that must be changed to meet the needs of the older patient. Some of these special care items include how we:

- talk to the patient
- instruct the patient
- help them with the activities of daily living (ADLs), including eating, bathing and personal care
- keep the patient or resident room safe and free of dangers
- respond to nurse call bells right away
- make sure the patient gets enough food and fluids

When caring for the older patient, the nursing assistant must show respect and call the patient by their name and not “mom,” “honey” or “grandma.” We must respect their rights and maintain their dignity. We must let them make their own choices, help them to be as independent as they can be, and keep them safe.

## **SECTION 2**

### **ALZHEIMER'S DISEASE**

#### **Objectives:**

After you take this class, you will be able to:

1. List the signs of Alzheimer's disease.
2. Discuss the stages of this disease.
3. Provide quality care to patients with Alzheimer's disease.

#### **What is Alzheimer's Disease?**

Alzheimer's disease is a very common problem among older adults. It is sometimes found in younger adults but it is most often seen in older adults. Nursing assistants and others provide care to patients with Alzheimer's disease almost on a daily basis. The class will give you the information you need to make sure that you are giving these patients the best care possible you can.

This disease continues to get worse after it starts. There is no cure for it. People with Alzheimer's disease can not think and act in a normal way when they get to the last or worst stage of this disease. Some very known people, like former U.S. President Ronald Reagan, have it.

Some people become completely dependent on others for their care and basic safety needs become very great. When this happens, the patient can no longer live on their own. They need the help of healthcare workers, like a nursing assistant. Some patients live in their own homes with the help of home healthcare aides and a home health agency. Others live in a nursing home or in an assisted living home because they need the care that they will get in these places.

This class will teach you about Alzheimer's disease, some of its signs and how you, the nursing assistant, can take care of people that have it.

#### **What are the Signs of Alzheimer's Disease?**

The 3 stages of Alzheimer's disease are:

- The early stage
- The middle stage
- The late stage

The signs of this disease get worse as time goes on and the disease continues to progress. The signs of each of the 3 stages are below.

### **Early Signs**

The first sign of this disease is usually short-term memory loss. The person may forget things that have recently happened. They can remember things that have happened a long time ago but they may not be able to remember what they had for lunch or dinner the day before or they may not be able to find their car keys because they forgot where they put them the day before. These people can remember things that happened a long time ago (long-term memory) but they forget things that are recent (short-term memory loss).

#### **People in the early stage also:**

- Repeat what they have already said. They forget what they have already said when they are speaking with other people.
- Forget the word they want to use. These people just can not find the right word to use in a sentence. They may even use a word that makes no sense at all.
- Forget how to do some simple things. Some may forget how to make their favorite stew, for example.
- Stop being able to do some “hands on” things. They may no longer be able to knit or drive a car as well as they did in the past.
- Have personality changes. They may become angry, aggressive, depressed and “moody.”
- Become disoriented. They may forget what day of the week it is.

Some of these changes are very small and hard to notice. It is often the family that notices it. The person may not even know they are having trouble.

### **The Middle Stage Signs**

As it continues to progress, the person will become more forgetful, confused and disoriented. They will have both short-term and long-term memory loss. The early stage signs get worse during the middle stage and the patient may also:

- Be restless and confused at night. This is often called “sun downer’s.”
- Have trouble reading and writing.
- Repeat actions over and over again. These acts have no purpose but they are done over and over again anyway.

- Wander and get lost. This is a big safety concern.
- Be at risk for harm. Falls, self harm and getting lost are a problem. These patients no longer see and stay away from danger. They do not have good judgment and common sense.
- Become aggressive and very angry. These behaviors may place the patient, staff and other patients at risk for harm.
- Not recognize family, friends and familiar place.
- No longer be able to take care of themselves without the help of others.
- Have hallucinations and delusions.
- Personality changes. They may be sad and depressed, have fears, anxiety and other personality changes.
- Lose social skills. These patients may stop spending time with others and doing things that you used to like doing.

### **The Late Stage Signs**

During the late stage, the patient can no longer care for himself or herself. They need complete care. All of the early and late stage signs continue to get worse and the patient also:

- Loses control of urine. They become incontinent of urine.
- Loses control of stool. They become incontinent of stool.
- Can no longer eat without a lot of help or a feeding tube. Patients may have eating and swallowing problems..
- Becomes underweight and thin. These patients are at risk for malnutrition, dehydration, infections and aspiration.
- Is highly irritable.
- Very sleepy and not responsive.

### **How do People Find Out that They Have Alzheimer's Disease?**

The diagnosis of Alzheimer's disease is not easy in the early stage of the disease. It is hard to separate normal forgetting things from the short term memory loss that marks this disease.

The doctor diagnoses this disease after a complete history and physical examination of the patient. Some mental tests and laboratory tests are also done. There is no blood test for Alzheimer's disease. The lab and mental tests that are done help the doctor to rule out other diseases that may be causing the patient's memory loss and other signs.



## **Caring for Alzheimer's Patients**

Nursing assistants and others in healthcare provide care to Alzheimer's patients according to their own needs. For example, if a patient in the early stage of the disease is able to dress and bath without help, we should help them to remain as active and as independent as possible. If the patient is at risk for falls, we must make sure that their room and the nursing unit is safe, secure, neat and uncluttered.

Below are some Alzheimer's disease health problems and ways that nursing assistants must provide care, as specific to these problems.

### **Confusion.**

- Keep the patient care area bright.
- Keep stimulation and noise to a minimum.
- Use large clocks, calendars and other things to orient the patient. Spend time with the patient. Remind them about the date, time of day and where they are.

### **Falls and other safety risks.**

- Keep the patient care area safe. Safety is VERY important. Keep the patient's room and the patient care area. Take away all clutter and dangerous chemicals, like medicines and cleaning liquids. Use non skid slippers and shoes for those at high risk for falls.
- Answer call bells promptly.
- Follow patient identification procedures. Very careful patient identification must be used to prevent medical errors and mistakes.

### **Wandering risk.**

- Use and attend to alarms. Bed alarms, alarms that ring when a wandering person tries to leave the building help keep patients safe. Listen for and respond to alarms immediately.
- Try to re-direct wandering. Some nursing homes have wandering or exercise tracks so that people can safely wander outside the building and in a big circle that ends in another entrance to the same building.

### **Lack of rest.**

- Alternate rest periods with activity. Tired patients may act out with behaviors that are disruptive, unacceptable or dangerous.

- Encourage sleep and rest by keeping a regular bed time. Give the patient a quiet room for rest. Have the person change into pajamas and keep a regular routine so that the person is able to sleep at night.

#### Eating problems.

- Encourage as much independence as possible.
- Know what the patient can and can not have. Some patients with a swallowing problem can not have plain water or other liquids. They may need honey thick fluids instead.

#### Behavior problems.

The best way to manage poor behavior is to prevent it. The best way to manage it is to stop it before it starts. The prevention of poor behavior needs the help of the whole team, including nursing assistants.

#### Prevent poor behaviors.

- Know your patients and residents. Know what kinds of things lead to poor behavior. Know the things that help your patient to behave correctly. For example, give the patient a bath in the morning if they are less confused and agitated in the morning. A bath during the afternoon or evening may make this patient angry and resist care completely. Very often, poor behavior happens while care is being given to a patient or resident. Try to calm a patient during care. Keep things the same and keep things simple to prevent poor behavior. Know the best routine for the person and stick to it.
- Know what triggers poor behavior and try to keep the person from these triggers. Eliminate all physical, emotional, environmental, communication and care triggers. Meet the person's needs so they do NOT react with disturbed behavior.
- Give simple instructions and repeat instructions if needed.
- Listen to the patient or resident. Many patients and residents will act out with poor behavior when they can't make their needs known. Spend time with your patient. Let them ask you questions. Help them tell you about their feelings. Help them tell you what they want. Use pictures if needed. Repeat back to them what you think they said or wanted to make sure you have really heard and understood them. Be clear and calm when communicating with these patients.
- Observe your patients and how they act with others. If another easily annoys a patient, encourage both patients to go to a different place for an activity or event.

- Approach a very confused patient from the side and speak face to face. Speak slowly, calmly and use simple words. Ask simple 'yes', 'no' questions.
- Keep the patient care area simple. Keep noise down. Make sure that there is enough light. Keep schedules and routines the same for people who act out when things are changed. Limit choices if needed. Some patients and residents get nervous and frustrated if they have too many choices. Encourage patients and residents to go to well supervised and structured activities if they are at risk for poor behavior when things are not structured.
- Keep your attention on the person and not the task. It is the person and how they are feeling that is important. If a person gets angry during an activity of daily living, break the task down into small parts. Encourage the person to be as independent as possible. Praise the person for their self care efforts.
- Provide activities that meet the patients' and residents' needs and prevents poor behaviors. Clocks and a large calendar or poster with the day of the week, the date, the season and the day's weather often help to orient people to time and current reality. Other socialization and activity groups, like reality orientation groups, holiday parties and reminiscence groups are often helpful.
- Relieve stress. Promote relaxation and other things that lower stress. Pet therapy, music therapy and socialization or exercise groups can lower stress.
- Report all patient changes to the nurse in charge. If a patient condition or behavior changes they may be at risk for acting out behaviors. Report all patient changes.
- Be a team member. Follow the patient's behavior management plan of care. Everyone on the team must be consistent. They must all say and do the same things with the patient.

MANAGE disruptive, unacceptable or dangerous behaviors when they occur.

- Stay calm, speak softly and show respect. If inappropriate, dangerous or disruptive behavior occurs, speak to the patient(s) calmly, slowly and with respect. Have them sit to chat. Sit next to them.
- Stop the task you are doing.
- Call for help if you need it.
- Protect all the residents from injury. Stay far enough away from a person so that they can't hit you. Try to sit the person down. Put a pillow on your

chest if a person is trying to punch you in the chest. Do NOT fight back. Do NOT pull away if you are grabbed. Stay calm and talk with the person. Remove the person(s) from harm if your words and instructions do not stop the dangerous behavior.

- Meet patient needs. If a person is making noise, find out if they are hungry, thirsty, wet, dirty, in pain, too hot, too cold or tired. Meet these needs. Feed the person that is hungry. Give water to the person who is thirsty, etc.
- Report any disturbed behavior. What triggered the behavior? What happened? When time was it? Where did it happen? How long did the poor behavior continue? Was the behavior mild, moderate or very severe? Who else was involved? What did you do to stop the behavior? Did it work?

## **SECTION 3**

### **INFECTION CONTROL**

#### **Objectives:**

After you take this class, you will be able to:

1. List some of the reasons why residents and patients are at risk for getting infections.
2. Discuss the cycle of infection and ways that you can break the cycle.
3. Detail the components of standard precautions and transmission precautions.
4. Describe specific ways to prevent the spread of infection, including handwashing, the proper use and disposal of gowns, gloves, masks, eye protection, handling hazardous waste and sharps, patient care supplies and equipment handling and environmental controls.

#### **What is Infection Control?**

Infection control helps hospitals, nursing homes, assisted living homes and other places where healthcare is provided. It stops the spread of infection, or germs, to patients, residents, staff and visitors.

We can all help control infections by doing special things in these areas:

- The environment. We can all help to keep the patient rooms clean and sanitary. Clean rooms and a clean hospital or nursing home spread less germs.
- Equipment and supplies. We must use sterile dressings on open skin surfaces to prevent infection. We must also keep patient equipment and supplies clean in order to prevent the spread of germs.
- Our work practices. All healthcare workers must make infection control a part of everything we do. We must use standard precautions. We must wash our hands and we must do several other things while we work in order to stop the spread of germs from one person to another. We must make infection control a part of everything we do.
- Our own state of health. Healthcare workers who come to work with a cold or flu can spread it to their patients. We must get enough rest, a good diet and the hepatitis B shot so that we can stay well and work without harming the ones we care for. We should also stay home when we have a bad cold, flu or another illness that our patients can catch from us.

- Our patients' and residents' state of health. Many older people and those with a history of breathing problems get the pneumonia and flu vaccines to protect them against these common illnesses.

### **Why Are Infections A Big Problem in Hospitals and Nursing Homes?**

Infections are a big problem in hospitals and nursing homes for many reasons. They are a problem because:

- We do not know when we are spreading germs. We cannot see them. They are very, very, very tiny and cannot be seen.
- People in hospitals and nursing homes are at great risk of getting an infection. Also, infections can spread very quickly in hospitals and nursing homes.
- They cause deaths, longer lengths of stay and they cost a lot of money.

Germs are very tiny. We cannot see them with our eyes as we work.

Germs are all over the world. They are found all over and in our own bodies. Some germs are good for us. These good germs keep us healthy. For example, we have good germs in our intestines that help us digest food and prevent other infections.

Many other germs can cause great harm and illnesses. Harmful germs that can make people ill are called "pathogens." They cause infections and diseases. They can cause wound infections, colds, pneumonia, AIDS/HIV and other diseases. Many of these diseases can cause serious harm and even death. These illnesses can be passed from one person to another without the person knowing that they are spreading it because these germs are very tiny and small. We cannot see them.

Invisible germs from our hands will grow and multiply in a couple of days if we rub our hand with a cotton swab and then wipe it on a special dish with food to grow. After a couple of days, we can put some of these grown germs under the microscope to see exactly what they are.

Germs will grow and multiply when they are fed and given a good place to live and grow. Nursing assistants and other healthcare workers can stop the growth of germs by taking away the things that feed germs and help them to grow. Germs like moisture and darkness. They grow very well when they are wet and kept in the dark.

Germs also like the food we eat. Leftover food on the patient's tray is more than enough food to grow germs. We can help in our battle against germs by keeping patients and their environment clean, dry and bright with light.

We can see dirt on our hands, but we cannot see germs on our hands. Handwashing is the best way to rid our hands of germs that we cannot see. Infection control must be a part of EVERYTHING we do.

### **People in hospitals and nursing homes are at great risk of getting an infection**

Infections spread very quickly in hospitals and other healthcare places for a couple of reasons. They spread quickly because people in hospitals are ill and very often weak. People that are ill and weak get infections because they are not able to fight it off as well as well as they could if they were healthy and well.

People in hospitals and nursing homes are also at risk for getting infections because they all live together in one area, rather than their own homes. Germs and disease can spread very quickly from one sick patient or resident to another when people live in a large group.

Our patients are also at risk for infection because they may have a weak and poor immune system. This makes them less able to fight off an infection. A disease, like AIDS/HIV, the common cold or the flu, some medications, old age and being an infant, can cause this weakness.

It is necessary that nursing assistants and other healthcare workers follow special infection control measures and restrict traffic in areas where there are infants, older people and very ill people. Some of these areas are the:

- labor and delivery room,
- infant nursery,
- new mothers area,
- special care units, like the ICU,
- kidney areas where people are more prone to infection,
- surgical care area and
- operating room where skin surfaces are broken with surgery

### **Infections Cause Deaths, Longer Lengths of Stay and a Lot of Money**

According to the U.S. Centers for Disease Control (CDC):

- more than 2 million infections start every year in a hospital, nursing home or another healthcare setting
- 70,000 people die every year as the result of getting an infection in a hospital, nursing home or another healthcare setting

- every infection that is caught in a hospital, nursing home or other healthcare setting costs over \$ 30, 000
- the United States spends more than \$ 45 billion every year for the extra care and treatment that is needed when infections start in a hospital, nursing home or another healthcare setting

The CDC states that the leading cause of death among residents in nursing homes is infection. Infection is also the most frequent reason for a person to be moved from the nursing home to a hospital for care.

1.5 new infections start every year in nursing homes. This number means that every person in a nursing home gets an average of one infection every year. (Centers for Disease Control, 2002)

Infections lower the person's quality of life and they cause pain and suffering to the patient and their family members. Again, infection control and the prevention of infections must be a regular part of everything we do. Infections are a big and costly problem in healthcare.

#### The Cycle of Infection: How Infections Spread

Infections can spread from person to person when germs:

- are able to leave the body,
- have a means of transportation and
- can enter another body

Germs are everywhere. They are in the air, on our body, in our body, on our clothes, on and in food, in liquids, in human waste, on table tops, bed sheets, flowers and everywhere else.

Nursing assistants can do many things to prevent the spread of germs. We must keep foods safe. We must make sure that patients' rooms are clean and without dust. Dust carries germs through the air.

Nursing assistants cannot prevent germs from leaving someone's body. Germs will leave a person's body when they cough, sneeze, move their bowels and when they have a draining wound. We have no control over a sneeze and a cough, but we do have control over the tissues that someone is using when they sneeze or cough. Tissues are a way for germs to move from one person to another.

Tissues and our hands are vehicles for germs, just like a car is a vehicle for us to move from one place to another. We cannot get to a far away store, work or church unless



we have a car or another mode of transportation to get us from our house to where we want to go.

Germes cannot move from one place to another unless they, too, have a means of transportation. If we take this away from them, they cannot move from one person to another. Tissues, hands and all other items that have, or may have, body fluids can move germs from one person to another. We can stop the spread of infection when we take the germs' transportation away.

We can break the cycle of infection and stop infections from moving from one person to another when we:

- wash our hands properly before and after EVERY patient contact,
- wash our hands properly before and after EACH task we do,
- handle all items that have, or may have, germs in the proper way and
- do other simple things like keeping dirty bed sheets away from our clothing

EVERYONE must control infection.

### **How Can Infections Be Stopped?**

Infections can be prevented and stopped when we:

- follow infection control and standard precautions procedures,
- handle hazardous waste properly,
- handle sharps properly,
- keep ourselves healthy,
- keep our patients healthy and
- wash our hands properly

### **Standard Precautions**

All healthcare workers must use standard precautions when they handle and throw out items that may have blood or another body fluid. All body fluids are able to transport invisible infections so we must use standard precautions whenever we handle any substance that may have an infection.

Some examples of body fluids are:

- blood
- feces

- wound drainage
- secretions from the nose
- saliva
- sputum
- tears
- urine
- vomit
- breast milk
- fluids taken from lungs, the abdomen, the spinal area, etc.

## USE STANDARD PRECAUTIONS FOR ALL PATIENTS & ALL BODY SUBSTANCES

We treat all patients as if they had an infection even when we are pretty sure that they do not. We must use standard precautions during all of our patient care.

### Standard Precautions Practices

#### **Handwashing Procedure**

You **MUST**:

- wash your hands before and after every patient contact and
- wash your hands before and after every task even if you have worn gloves. Gloves are NOT a substitute for handwashing. Learn more about handwashing below.

#### **Gloves**

You **MUST**:

- wear gloves whenever you may touch any body fluid, including when you empty a urine bag, urinal or bed pan,
- remove your gloves and throw them away after each use in the proper manner. Most hospitals and nursing homes use red bags to throw away gloves and all other things that are not sharp.
- NEVER use gloves more than once. They must be thrown out after every use. They CANNOT be re-used.
- Wash your hands immediately after taking off your gloves and

- NEVER walk around the hall with gloves that have touched a patient or a body fluid

### **Masks, Eye Protection & Face Shields**

You MUST:

- use personal protective equipment like a mask, eye protection and a face shields if you are near a patient care activity that may involve a splash or spray of body fluids,
- use a special mask or an Ambu-bag when you are doing CPR or rescue breathing and
- dispose of all single use personal protective equipment immediately after use.

### **Gowns**

You MUST:

- wear a gown when you are doing something that may soil your clothes with body fluids. You should wear a plastic gown when the body secretion is wet. A plastic gown does not let wet body fluids go through the gown to your clothes or uniform.
- take the gown off, throw it away and
- wash your hands immediately after taking the gown off.

### **Patient Care Equipment and Supplies**

You MUST:

- carefully handle all dirty patient care equipment so that it does not touch your clothing or another patient,
- use single use patient supplies with one patient. Do NOT share these items with other patients.
- throw away all single use patient care equipment and supplies in the proper manner and
- write the patient's name and room number on all patient care supplies, like urinals and bedpans.

## **Environmental Control**

You MUST:

- routinely clean all visibly dirty items such as bedside tables and night stands,
- make sure that all wheelchairs, beds, rails and walkers are kept routinely kept clean by the house keeper or another person at your hospital or nursing home and
- keep your own food and drinks out of patient care areas and only in the staff refrigerator. These items cannot be put in the medication refrigerator or the patient refrigerator.

## **Linen**

You MUST:

- keep the linen cart covered
- keep all linen off the floor
- keep dirty linen and all other objects away from your body and clothing and
- place dirty linen in the proper bag

## **Patients' Beds and Chairs**

You MUST:

- NOT sit on patient's beds or chairs. Sitting on patient beds and chairs can spread infections to patients and residents from our uniform.

## **Transmission Precautions**

At times a person may have an infection that is very hard to control. We use special transmission precautions, in addition to standard precautions, when a person has an infection that is hard to control. For example, special transmission precautions are necessary when a person has TB, a severe virus infection, the mumps or another disease that others can catch very quickly.

People with these special precautions are usually kept in a private room. There are 3 kinds of these precautions:

1. airborne
2. droplet
3. contact or touching

A person with TB is put on airborne precautions. When a person has TB they are put in a special room and a sign is put outside of the person's door. This sign tells you what you must do before you enter the room, what you must do while you are in the room and what you must do when you are leaving the room. All people going into their room must wear a special mask, called a HEPA mask.

A person with a bad respiratory infection, like the mumps or the flu is put on airborne isolation. Nursing assistants and other health care providers have to wear a regular mask when they enter this person's room.

People are put on contact precautions for serious wound or skin infections and for bad infections that affect the gastrointestinal tract. It is necessary to wear a gown and gloves when entering the room of a person that is on contact isolation. You must also use a special soap when washing your hands.

### **Special Waste Handling**

Everyone must also throw away all body fluids and trash or waste as if it were infected with germs in order to prevent infections from spreading.

We must throw away all gowns, gloves, masks, bandages and other items, other than sharp items, in a special red bag. This red trash bag contains hazardous waste. These special red bags are moved and handled by people that have been trained about how to do it safely.

### **Safe Handling of Sharps**

Infections can be prevented when we handle and throw away sharp objects and items, such as needles, in the proper way. Because needles and sharp objects may break through the red trash bags, they must be put into hard puncture proof containers. Many of these hard red containers are found on the walls of the patient rooms and on the nurses' medication cart. These sharp items are also treated as hazardous waste.

### **Keeping Yourself Healthy**

There are many things that you can do to stay healthy. When you keep yourself healthy you can easily fight off many infections. Your patients cannot get an illness or infection from you when you are healthy.

- Eat a good diet,
- Get plenty of rest,
- Exercise,
- Manage your stress,

- Get a hepatitis B shot if you have not already had one,
- Get the flu shot every year,
- Get the pneumonia shot if your doctor thinks that it is a good idea for you to get one and
- Stay away from other sick people in your home, as much as possible.

You should not go to work if you have been exposed to an illness like measles and if you have a cold with a fever or heavy mucous, the flu or another infection.

If other members of your household or family are affected with an infectious disease such as tuberculosis, pneumonia, chickenpox or the measles, you should also call your supervisor.

### **Keeping Your Patients and Residents Healthy**

Nursing assistants and other healthcare providers can work together to keep their patients and residents as healthy as possible.

We can help them to:

- get a good diet,
- get plenty of fluids,
- get enough sleep and rest,
- manage their stress,
- get their flu, pneumonia or hepatitis B shots and
- stay away from infections and other sick people, as much as possible.

### **Handwashing**

Simple handwashing is the single most effective thing that we can do to prevent the spread of germs and infection in hospitals, nursing homes and other healthcare places. The success of handwashing has been proven over and over again. Yes, handwashing is the MOST important thing that you can do to prevent the spread of infection from one person to another.

Healthcare worker hands carry most infections. It is our hands that carry germs from one person to another. We must wash our hands, keep our nails short and clean and avoid wearing a ring, other than a small and clean wedding band. Germs like to hide under moist and dark nails and rings. Rings and nails transport germs.

You use soap, water, lots of rubbing and a little time to wash your hands. Never hurry through the process. Do not ever skip a step. Do not forget to wash your hands. Remember, infections from your hands can kill your patients.

## **Handwashing**

You **MUST** wash your hands:

- as soon as you come to work
- before you go into a patient or resident room
- when you are leaving a patient or resident room
- before and after each task you do
- before and after you touch a person
- before and after you put gloves on
- before you leave a rest room
- before taking a break
- before and after you eat or handle food
- after you cough or sneeze
- after you blow your nose
- after handling garbage or trash
- when you are leaving work

**REMEMBER- WASH YOUR HANDS BEFORE & AFTER EVERY PATIENT CONTACT OR VISIT**

### **Proper Handwashing**

The correct hand washing procedure is simple and takes less than 20 seconds to complete.

These are the steps that you must follow when you are washing your hands:

1. Turn on the water
2. Wet your hands up to your wrists
3. Apply a good amount of soap to your hands and wrists while the water remains running
4. Rub your hands together to work up suds

5. Rub the front and back of your hands, rub between your fingers, rub around the edges of your nails, clean under your nails, rub your wrist up to about 8 inches above your hand. **THIS RUBBING SHOULD CONTINUE FOR AT LEAST 15 SECONDS.** Hold your hands down lower than your elbows, but do NOT touch any part of the sink. Put a little more water on your hands if the soap dries out while you are rubbing.
6. Rinse your hands well under the running water without touching the sink and while keeping your fingers LOWER than your wrist
7. Take a paper towel and dry your hands
8. Turn the water off with the paper towel, NOT your clean hands
9. Throw the paper towel away

If you forget a step, start all over again from step 1. If you make a mistake and touch the sink, start all over again from step 1.





## SECTION 4

### ADULT CARDIOPULMONARY RESUSCITATION

#### Deciding to Act

1. Good Samaritan Law
2. Reconizing an Emergency
  - A. Odors
  - B. Symptoms of Diseases
  - C. Unusual appearance or behavior

#### Emergency Action Steps

1. Check: *First step in the Emergency Action Steps* 
  - A. The *Scene*: (Is it safe for you, bystanders and the victim?)
  - B. The *Victim*: (look for immediate life-threatening conditions)
    - (1) If the victim is unconscious **Call 911** and check for breathing and a pulse
    - (2) If the victim is conscious, does the victim have chest pains, or is there severe bleeding?
    - (3) Reassure the victim that help is on the way and things will be okay
2. **Call**: *Most Important thing to do is to call 911 if you have a life threatening situation* 
  - A. Phone 911 (EMS) Emergency Medical System; Give
    - (1) Location, telephone, what happened
    - (2) Victims condition and what is being done
3. **Care**:
  - A. Watch for changes in the victims condition
  - B. Treat more serious injuries first
  - C. Treat for shock and reassure the victim
  - D. Provide care until advanced help arrive

## **Checking an Unconscious Victim**

1. Unconscious Adult: is there breathing - a pulse, severe bleeding?
  - A. Check for unresponsiveness - (Tap and ask "are you okay") - if no response call EMS 911
  - B. Check for breathing - Look, listen, and feel (5 seconds) - if face down and you can not tell:
    - (1) Position Victim - ROLL VICTIM ONTO THEIR BACK AS A SINGLE UNIT
  - C. Open the Airway - head tilt / chin lift
    - (1) If you suspect a spine injury use the chin lift only
  - D. Look, listen, and feel (5 seconds)
    - (1) Check for severe bleeding while checking for breathing
  - E. If not breathing, give two slow breaths
    - (1) Watch the chest rise. Do not over inflate lungs, as excess air will enter the stomach and may cause the victim to vomit  
Check carotid pulse (5-10 seconds) - The groove on the side of the neck next to the Adam's Apple - closest to rescuer – use 2 to 3 fingers to feel
2. If you must leave the victim to call for help - roll the victim on their side, extend the arm closest to the ground above their head and bend the knee farthest from the ground to keep the victim from rolling onto their stomach

## **Checking a Conscious Victim**

1. Survey the scene (Look for conditions that may be life threatening to you and/or the victim)
2. Attempt to find out what happened (Interview the victim and/or any witnesses)
3. Check the victim for any injuries or deformities.
  - A. Check the victims head for any fluids or blood running from the ears or nose
  - B. Check for breathing (Is it fast, slow, or are they gasping for air?)
  - C. Check their temperature (Feel the forehead with the back of your hand)
  - D. Have the victim shrug their shoulders.

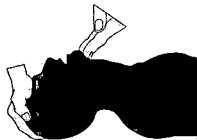
- E. Have the victim take a deep breath (This checks the upper torso and chest area for injuries)
- F. Have them check their arms and legs by gently squeezing

### If a Person is Choking



1. Conscious Adult
  - a. Good air exchange- *do nothing encourage victim to cough (call EMS 911)*
  - b. Poor air exchange (wheezing or gurgling sounds) begin abdominal thrusts from behind the victim by placing the thumb side of your fist against the victim's abdomen just above the naval and well below lower tip of breastbone (quick upward thrusts) until object comes out, victim starts to cough, or the victim passes out.
2. Chest thrusts:
  - a. Pregnant women and extremely large persons (use chest thrust in lieu of abdominal thrusts)
3. If you are alone use a chair or the corner of a table

### Rescue Breathing



1. Performing Rescue Breathing
  - a. Check for unresponsiveness (Tap and ask are you okay?) if no response call EMS 911 can not tell:
    - (1) Position Victim – **ROLL VICTIM ONTO THEIR BACK AS A SINGLE UNIT** one hand on the hip)
  - c. *Open the Airway - head tilt / chin lift*
    - (1) If you suspect a spine injury use the chin lift only

- (1) Check for severe bleeding
- e. If not breathing, give two slow breaths – while pinching the nose shut
  - (1) Enough to make the chest gently rise
- f. Check carotid pulse (5-10 seconds) - The groove on the side of the neck next to the Adam's Apple - closest to rescuer -use 2 to 3 fingers to feel - while listening for breathing
- g. If there is a pulse and no breathing - begin Rescue Breathing
  - (1) 1 slow breath every 5 seconds
  - (2) 1 and 1/2 seconds in length for each breath given
- h. Check pulse every 12 breaths (about a minute)
- 2. Cyanosis - blue discoloration from lack of oxygen
  - a. If victim is cyanotic give two slow breaths (one hand supporting the neck - and immediately
- 3. Gastric distention- over inflation of the lungs causing air to enter stomach may cause the victim to disgorge the stomach contents - if this occurs roll the victim onto their side and sweep the mouth clear with your finger and continue rescue breathing
- 4. Mouth-to-Nose Breathing used when the mouth or jaw is injured and mouth-to-mouth is not possible
- 5. Stoma - Victim will have an opening in the neck for breathing due to conditions which have caused the windpipe to be closed off. This stoma will serve in the same capacity as would their mouth.
- 6. Human body needs 5% oxygen, the air we breath contains 21% oxygen

### **Unconscious Choking Adult**

- 1. Steps to follow after you determine the airway is obstructed
  - a. Two slow breaths: if airway appears obstructed
  - b. Re-tilt head and give two additional slow breaths (4 total)
  - c. If air still does not enter the lungs Call 911
  - d. Give the victim up to 5 abdominal thrusts (while lying on back
  - e. Do finger sweep (grasp both tongue and lower jaw between thumb and fingers of hand nearer victim's legs and lift jaw. Insert index

- finger into mouth along inside of cheek and deep into throat. Use a hooking action to dislodge any object that might be there
- f. Give two slow breaths, continue cycle until air enters lungs
- g. Position hands on the middle of the abdomen above the navel and below the lower tip of the breastbone.
- h. Thrusts help a choking victim by forcing the air in the lungs out through the airway to push an object out

## Heart Attack

1. Heart disease is the 2nd leading cause of death in the U.S.
2. Most victims die within 2 hours of the heart attack
3. One and a half million heart attacks are experienced annually
4. 300,000 deaths are the result/ 75 percent could be saved (225,000)
5. Heart disease most common reason why an adults hearts stops beating
6. One out of every two people die from heart disease annually
  1. Signs and Symptoms
    - a. Persistent chest pains or discomfort – most significant sign of a heart attack
    - b. Sweating, nausea / vomiting
    - c. Shortness of breath
    - d. Pain may radiate to left arm, jaw, neck, or shoulder
    - e. Many victims deny they are having a heart attack.

## CPR



1. (CPR) WHEN THERE IS NO PULSE
2. CPR is only 25% as effective as the heart working itself
  - a. *2 slow breaths to each 15 compressions (per cycle)*

- b. Compress chest 2 inches deep / hand located 2 finger width's above the lower end of the sternum - lock your elbows and put your shoulders directly over your wrists
  - c. The 15 compressions should be smoothly administered and completed in approximately 10 seconds
  - d. Monitor pulse approximately every 1 to 2 minutes
  - e. Purpose of CPR is to circulate oxygen-rich blood to all parts of the body when the heart has stopped.
- 3. Second rescuer relieves first rescuer: check pulse, give two breaths, resume CPR
  - 4. Stop CPR when emergency help arrive, the scene becomes unsafe, when you are exhausted.

## **SECTION 5**

### **END OF LIFE CARE**

#### **Objectives:**

After you take this class, you will be able to:

1. Use end of life care principles in your daily role as a nursing assistant.
2. Detail the physical, mental, social, spiritual, financial and communication needs of patients and their family members as the end of life is near.

#### **What Is End Of Life Care?**

People of all ages go through the natural dying process unless they have had a sudden illness or accident. Babies and young children who are born with AIDS/HIV go through a dying process. Adults with cancer also go through the end of life process. The end of life requires special nursing care.

If a person is shot with a gun or is in a very bad car accident, they may die in an instant without the end of life process because their death was sudden. Their needs are not the same as those who died in a slower and more gradual way.

The years, months or days before death are often filled with more and more physical and mental problems for most people as they go through the end of their life. These people need special care as they go through the natural dying process.

#### **WHAT DO PEOPLE NEED DURING THE END OF THEIR LIFE?**

Some of the resident, patient and family member needs at the end of life are listed below.

- **Communication.** Communication can be verbal, or spoken and it can be nonverbal. An example of verbal communication is saying, “Hello, Mrs. Rochas, how is your arm feeling today?” Communication can also be nonverbal. This communication is sometimes called body language. If you stand in a person’s room and tap your foot **WITHOUT** saying a word, you are telling the person that you are in a hurry **WITHOUT** ever saying a word. Foot tapping is nonverbal communication.
- **Physical comfort.** Many patients at the end of life are in pain. Some need pain medicine and other pain relief care. Many may be chilly, or feel cold. They may also lose control of their urine and feces. Patients at the end of life need physical care and comfort.
- **Mental comfort.** Some people may be very sad, or depressed. Others may be afraid to be alone in their room. Many people accept the fact that they

are dying. They accept the fact that death is near and they prepare for it. They may do certain things like taking care of their money matters, selling their house, giving their possessions away and writing a will, if not already done. All patients and residents must be treated with dignity and kind care at all times throughout their life, especially as the end of life comes. A lot of special care is needed during this time to make the person mentally comfortable.

- Spiritual comfort. People may want to see a rabbi, priest or minister during the end of life. They may want to pray, go to church and read the bible. Others may not be spiritual or religious at all.
- Social needs. Sadly, many old people and very ill people do not see or hear from their family or friends as much as they did in the past. They may feel lonely, unloved, and not useful or important.
- Financial needs. Care in the home, hospital or nursing home costs a lot of money. During the end of life, many people worry about how they are going to pay for their funeral and their health care. Some need help from a social worker or community agency to meet these financial needs.

### **Meeting the Needs at the End of Life**

Nursing assistants play a very important role in end of life care. They should observe and report all end of life needs to the charge nurse. They also provide end of life care. For example, a nursing assistant must report when a patient tells them that they would like to see a minister so that the minister can visit with the dying patient. They may also be asked to sit and talk to a resident so the resident will not fear being alone.

Nursing assistants also must care for the family. We must allow families to spend a lot of time with the loved one that is dying. Make the family comfortable. Give the family privacy.

Tell the family and other visitors where the telephones are. Show them the rest rooms and the coffee shop. Arrange for visitor meals to the patient's room if they want meals.

Other ways that nursing assistants can meet the needs of the dying patient and family.

### **Communication**

- Spend time with the patient and family.
- Listen to what they have to say.
- Speak in a kind and respectful way.
- Answer their questions if you can. If you can't answer a question, ask the nurse to help them.



- Use body language that shows caring and respect. A gentle touch, holding the person's hand and just spending time shows caring. Do NOT cross your arms, tap your feet or show other signs of being hurried.
- Communicate with patients that are in a coma or unconscious. Do NOT treat unconscious patients different from those that are awake and alert. Do NOT ever say anything that you do not want the patient or resident to hear. Hearing is the last sense to die at the end of life.

### **Physical Comfort**

Patients during the end of life have physical care needs. Many patients at the end of life choose to NOT have some treatments, such as CPR, tube feedings and other things. This is their right. They can choose to have some nursing care and choose to NOT have other things. All patients, however, have a right to physical comfort.

- Observe and report signs of pain. Tell the nurse if a person tells you that they are in pain or if you see an unconscious person with a look of pain on their face. Pain is now called the 5th vital sign. Patients should be checked for pain often.
- Provide a quiet room, a backrub and even soothing music to patients that are in pain. Allow the person in pain to speak to you. Spend quiet time with them.
- Give the person their bath and provide very good skin care. Keep them clean and dry at all times.
- Turn and position the patient at least every 2 hours. Many dying patients are at risk for pressure ulcers.
- Provide very good mouth care. The patient may be dehydrated and have a dry mouth. Use mouth swabs for unconscious patients that have a dry mouth. Give sips of water to patients that are conscious and able to swallow safely.
- Keep the bed and the room neat.
- Adjust the temperature in the room if the person is too warm or too cold. Give them lighter clothing to wear if they are hot. Give them a sweater or blankets if they are cold.

### **Mental Comfort**

- Listen to the patient, resident or family members. Spend time with them. Allow them to express their fears and concerns.
- Keep the nurse call bell in reach of the person so they can call for help if they need it.

- Answer the call bell immediately. Do NOT ignore any person or their needs when they need your help, especially at the end of life.
- Allow the person to do their end of life tasks, like calling their family and speaking to their attorney or funeral director.
- Make the person feel loved and cared for.
- Report any signs mental distress, like crying, to the nurse.

### **Spiritual Comfort**

- Respect the need for spiritual support.
- Do NOT force your own religious or spiritual beliefs on the patient. People have the right to choose their own beliefs. These beliefs must be respected. People also have the right to have no religious or spiritual beliefs at all.
- Provide a quiet and private place to pray, read the bible, meditate and speak to their religious chaplain.
- If a person wants to see their rabbi, priest, or other religious representative, report this to the nurse.

### **Social Needs**

- Welcome visitors. People at the end of life have a desire for closeness. Make visitors comfortable and welcome.

### **Financial Needs**

- Tell the nurse if the person is worried about their money or financial needs. Social workers often help them with these and other matters, such as writing a will or advance directives.

### **Post Mortem Care**

- Allow the family to cry, grieve and spend some time with the person who has died.
- Follow your hospital or nursing home procedure for post mortem care.
- Provide post mortem care with dignity and respect for the person that has died.

## **Legal & Ethical Issues at the End of Life**

### **The Right to Dignity**

All patients and residents have a right to dignity throughout their life, especially when the end of life is near.

- Provide privacy when bathing or caring for a patient.
- Encourage the person to make choices and control their own life. If they want to wear a certain dress, let them wear it. If they want their bath in the evening instead of the morning, let them have their bath in the evening.
- Allow the person to be as independent as possible.
- Speak to the person with respect. Call the patient by their name. Do not call them “mom,” “honey” or “grandma.”

### **The Right to Make Decisions**

All patients and residents that are capable of making a decision must be able to do so, even when the end of life is near.

- A person can choose what they want and what they do NOT want. If a person refuses care, do NOT force them. Some people do not want a lot of medications or treatments like CPR at the end of life. Others choose to have CPR and medications. Know your patients and residents. Respect and carry out their wishes.
- If a person has enough thinking ability (competence) to make a decision, their decision must be respected. Family members, nursing assistants and all others MUST respect these decisions, even if we do not agree with them.

### **The Right to Privacy & Confidentiality**

Patients and residents have a right to have their medical information secret and private. NEVER discuss a patient or their condition with friends, neighbors, other patients or residents.

- Do NOT discuss any information about the patient or resident unless the patient or resident asks you to.
- Keep patient information confidential. It is against the law to tell your family member or neighbor that “Mr. B., my patient is dying with AIDS.”

- Do NOT discuss any information about your patients with other patients or unknown people that have called the nursing station. You have no way of knowing who is at the other end of the phone.

### **A “Living Will”: Advance Directives**

Patients and residents across the country are encouraged to write what treatments they do and do NOT want when they are at the end of life. These things are put in a “living will” or “advance directives”

- Know your patients and residents.
- Know what your patients and residents want and do NOT want. Do NOT do CPR, for example, on a patient who does NOT want it.
- Respect these wishes even if you do not agree with them.

### **Medical Power of Attorney: Health Care Proxy**

Some patients and residents choose to have others make decisions for them. These people may decide what treatments the patient or resident will and will not get when the person is no longer able to make a choice at the end of life.

- Follow the decisions of the medical power of attorney or health care proxy

### **Summary**

Nursing care does NOT stop when the end of life comes. All members of the health care team play a very important role in the end of life care. This care meets the person’s physical, mental, social, spiritual and financial needs.

Nursing assistants and others must be able to meet these needs. They must also be able to care for family members while they hold up the patient’s or resident’s rights to decision making, privacy, confidentiality and dignity.

## REFERENCES

- Abruzzese, R. S. (1992). Nursing staff development, strategies for success. Saint Louis, MO: Mosby Year Book.
- Austin, E. K. (1981). Guidelines for the development of continuing education offerings for nurses. New York: Appleton-Century-Croft.
- California Code of Regulations, (1995). Vol.30 Title 22. Social Security.
- Cooper, S. S., & Hornback, M. S. (1973). Continuing nursing education. New York: McGraw-Hill.
- Dock, L. (1920). A short history of nursing: From the earliest times to the present day. New York: G.P. Putman's Sons.
- Erikson, E. (1963). Childhood and society (2nd ed.). New York: WW Norton.
- Faculty-Curriculum Development. (1974). The process of curriculum development. New York: National League For Nursing.
- Nettina, S. M. (2001). The Lippincott manual of nursing practice (7th ed.). Philadelphia: Lippincott, Williams and Wilkins.
- Popiel, E. S. (1973). Nursing and the process of continuing education. Saint Louis, MO: The Mosby Company.
- Popiel, E. S. (1977). Nursing and the process of continuing education. Saint Louis, MO: The Mosby Company.
- Sheehy, G. (1995). New passages: Mapping your life across time. New York: Ballantine Books.
- Sorrentino, S. (2000). Nursing assistants. St Louis, MO: Mosby.

Tobin, H. M., Hull, P. K., & Wise, P. S. (1979). The process of staff development. Saint Louis, MO: The Mosby Company.